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硕 士 学 位 论 文

论城镇医疗保障体系过度医疗问题及对策

The Excessive Medical Care in Chinese Urban Medical Insurance System and Corresponding Counterplan

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摘 要

2014 年，中国人均 GDP 突破 7500 美元（现价），迈入了向发达经济体过渡的新阶段。人均收入水平的上升促进了需求结构的转变，服务产品需求迅速增长，经济服务化趋势愈发明显，2013 年第三产业占 GDP 比重首次超过第二产业，成为国民经济的最大产业。民生服务业作为其重要组成部分，不仅关系到宏观经济的整体运行，还牵涉广大民众的切身需求，其重要性不言而喻。

在众多民生服务业中，医疗服务的需求增长迅速，但受到既有体制的限制，医疗服务的供给难以有效满足社会需求。医疗及医疗保障体制虽然经过多番改革，但成效并不显著，医疗费用过快增长等问题大有愈演愈烈之势。根本原因之一在于尽管改革方案层见叠出，但始终没有理清作为社会保障体系之一的医保和作为医疗服务企业的医院之间的关系。医院作为医疗服务提供方，职能就是为广大患者减轻疾病痛苦，而医保作为规避疾病风险的手段，主要在于降低患者的经济负担。医院过多的承担着医保的责任，致使医方利用其信息优势地位诱导患者过度医疗而得不到有效制约，医疗费用增长得不到遏制。因而合理的医疗社会保障体制应当区分二者，使医院能有效地提供医疗服务产品，而医保能帮助患者购买医疗产品并对医院实行监督。

本文分析中国医保制度尚存在的突出问题及原因，并在借鉴国际医疗改革经验的基础上，提出引入第三方保险机构检查监督功能的创新性方案。通过利用委托代理理论的模型分析得出结论，在基本模型中，由于信息不对称，医生有可能采取诱导患者过度消费的欺骗行为，并且这种行为与患病严重程度可能性相关。在扩展模型中，由于引入保险方的监督检查功能，使得这一可能性明显变小，但并不能完全消除。由此在政策建议上，我们提出社会医疗保障体制应当区分作为医疗服务提供方的医院方和费用承担者的医疗保险方，使二者各司其职。医院应从依靠政府投入为主的事业单位转变为民生服务企业，但要接受政府管制。医疗保险基金完全可以按照商业保险模式来运作，但要实行强制参加原则以避免逆向选择。另外，必须赋予保方对医方行为的监督检查功能，以对医院的机会主义行为进行有效监督，这样方能解决过度医疗问题。在医保基金运作上，可以引入市场竞争机制，以避免单一商业医保基金可能形成的垄断势力。竞争能促进各保险方提高保险产品质量，优化服务，并对医院实行有效监督，而政府则可以对医保

基金市场运营履行监管职能。

关键词：医疗保险；过度医疗；体制改革

Abstract

In 2014, with the per capita GDP for an average Chinese exceeding 7500 US dollars (if calculated by current prices), China is now advancing towards a new phase of becoming a developed economy. With the rise of the per capita income propelling the transformation of the demand structure, demands for service products develop rapidly and the service-based economy is gaining new momentum. In 2013, the ratio of the third industry in GDP surpassed that of the second industry for the first time, becoming the largest pillar supporting the national economy. As an important part of the third industry, the service sector involving the livelihood of people, concerns not only the overall functioning of the macro economy, but also the urgent needs of the general public. Therefore, its importance can never be over exaggerated.

The demand for the medical service roared, but due to the limitations of the existing system, the supply for the medical service can not meet the social demand. Although several rounds of reform concerning medical care and medical care insurance system have been undergone in the past, the results of these reforms are limited and the growth for medical costs seems to be continuously aggravating. One fundamental reason is that although medical care reforms keep flaring up, the relationship between medical care, which is a part of the social insurance system, and hospitals, which are embodiments of medical service enterprises, is not clarified. Hospitals, as medical care service providers, mainly aim to alleviate the pain of patients. Medical care insurance, however, as a method of avoiding risks, mainly lessens the economic burden of patients. Because hospitals undertake the major responsibility of medical care, they can utilize information advantages and lure patients to excessive medical care without any restrictions, resulting in a skyrocketing rise in medical costs. Therefore, a rational medical care insurance system is supposed to clearly distinguish the responsibilities of medical care insurance and hospitals so that hospitals can provide effective medical care products while medical care insurance can help patients buy medical care products and supervise hospitals.

The paper, on the basis of briefing the existing problems for China's medical care insurance system and the reasons, as well as learning from the successful experience of international medical care reforms, put forward an innovative solution – to introduce a third party insurance agency to perform its supervision and check function. Through the model analysis for Principal-agent Theory, the author draws the conclusion that in the basic model, owing to asymmetric information, doctors are liable to cheat patients into over consumption and this behavior bears likelihood to the severity of getting diseases. By contrast, in the extended model, because the insurance company performs its supervision and check function, the above-mentioned likelihood can be lessened to a certain amount but still not fully eliminated. In consequence, the author proposes in the final suggestions that social medical insurance system should first of all distinguish the responsibilities for hospitals, as medical service providers, and medical insurance companies, as cost bearers. Hospitals should transform themselves from public institutions which mainly rely on government input to companies which are to improve people's livelihood but still under government administration. Medical care funds can function as business insurance model, but forced participation is needed to avoid adverse choices. Besides, if insurers can exercise supervision and check function over hospitals and the opportunistic behaviors of hospitals can be properly motivated, the problem of excessive medical care can be solved. While medical care fund is being given full play, a market competition mechanism can be introduced so that a single business medical care fund can not have absolute monopoly. By way of competition, insurers can compete with each other to raise the quality of their insurance products, improve services, and exercise effective supervision over hospitals, while the government can play a supervision role in medical care insurance fund market.

Key words: Medical care insurance; Excessive medical care; System reform.

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